SANTA CRUZ CITY SCHOOLS
CLASSIFIED & CONFIDENTIAL
MONTHLY MEDICAL BENEFITS COST TABLE
EFFECTIVE 10/01/2023 - 9/30/2024

	HMO PLANS			PPO PLANS	
	BLUE SHIELD HMO $25-500 #1H031001 **PLAN ID: HMOBSH**	**BLUE SHIELD HMO $25-500 TRIO** #1H131001 **PLAN ID: HMOPMG**	**KAISER HMO $0-0** #605337-0006 **PLAN ID: HMOK**	**BLUE SHIELD PPO 90-E $20** #0P031001 **PLAN ID: PPOBSH**	**BLUE SHIELD PPO 80-K $30** #0P051001 **PLAN ID: PPOBSL**
Individual/Family Deductibles	N/A	N/A	N/A	$300/$600	$1,000/$2,000
Out of Pocket Maximum	$2,000/$4,000 20% Deductible	$2,000/$4,000 20% Deductible	$1,500/$3,000	$1,000/$3,000	$3,000/$6,000
Office Visit Co-Pay	$25	$25	$0	$20	$30
Prescription Drug Plans (Out of Pocket Maximum)	$5/$20 RX, $1,500/$2,500	$5/$20 RX, $1,500/$2,500	$5/$5 RX, $1,500/$3,000	$7/$25 RX, $1,500/$2,500	$5/$20 RX, $1,500/$2,500
Network	Full Network	PAMF & Sutter Health EXCLUDED	KAISER ONLY	Full Network	Full Network
Monthly Premium					
SINGLE	**$1,156.00**	**$1,058.00**	**$1,004.00**	**$1,328.00**	**$1,160.00**
2-PARTY	**$2,253.00**	**$2,058.00**	**$1,956.00**	**$2,601.00**	**$2,260.00**
FAMILY	**$3,162.00**	**$2,885.00**	**$2,750.00**	**$3,662.00**	**$3,173.00**
FULL TIME EMPLOYEE (0.8750-1.0 FTE) MONTHLY CONTRIBUTION	**Employer** / **Employee**				
SINGLE (EMPLOYEE ONLY)	$1,119.30 / $36.70	$1,058.00 / $0.00	$1,004.00 / $0.00	$1,141.60 / $186.40	$1,120.30 / $39.70
TWO PARTY (EMPLOYEE + ONE)	$2,164.40 / $88.60	$2,058.00 / $0.00	$1,956.00 / $0.00	$2,210.70 / $390.30	$2,165.80 / $94.20
FAMILY (EMPLOYEE + TWO OR MORE)	$3,023.20 / $138.80	$2,885.00 / $0.00	$2,750.00 / $0.00	$3,090.10 / $571.90	$3,025.60 / $147.40
PART TIME EMPLOYEE (0.5-0.8125 FTE) MONTHLY CONTRIBUTION	**Employer** / **Employee**				
SINGLE (EMPLOYEE ONLY)	$1,119.30 / $36.70	$1,058.00 / $0.00	$1,004.00 / $0.00	$1,141.60 / $186.40	$1,120.30 / $39.70
TWO PARTY (EMPLOYEE + ONE)	$2,107.53 / $145.47	$2,058.00 / $0.00	$1,956.00 / $0.00	$2,153.83 / $447.17	$2,108.93 / $151.07
FAMILY (EMPLOYEE + TWO OR MORE)	$2,866.22 / $295.78	$2,831.42 / $53.58	$2,750.00 / $0.00	$2,933.12 / $728.88	$2,868.62 / $304.38

CLASSIFIED BENEFITS	Monthly Premium
DENTAL INCENTIVE PPO	$110.00
DELTA DENTAL UNLIMITED PPO	$117.00
CLASSIFIED & CONFIDENTIAL - VSP	$15.80
LONG-TERM DISABILITY	$17.12
LIFE INSURANCE	$5.35

CONFIDENTIAL BENEFITS	Monthly Premium
DENTAL INCENTIVE PPO	$110.00
DELTA DENTAL UNLIMITED PPO	$117.00
CLASSIFIED & CONFIDENTIAL - VSP	$15.80
LONG-TERM DISABILITY	$17.12
LIFE INSURANCE	$21.42

The employee's share costs are negotiated annually by your union and therefore are subject to change.
Your cost will be deducted from your payroll check in 10 equal installments starting in October. As the withdraw will be done in 10 installments, the monthly cost will be higher than the amount stated in the

SISC
Self-Insured Schools of California
Schools Helping Schools

Santa Cruz City Schools - Classified & Confidential - SISC Medical Plan Comparison Effective OCTOBER 1, 2023 - SEPTEMBER 30, 2024

SISC PLAN NAME	Blue Shield HMO-Full (includes PAMF) $25-500, Rx 5-20 PLAN ID: HMOBSH	Blue Shield TRIO HMO $25-500, Rx 5-20 PLAN ID: HMOPMG	Kaiser HMO $0 CO PAY, Rx 5-5 PLAN ID: HMOK	Blue Shield PPO 90-E $20, Rx 7-25 PLAN ID: PPOBSH	Blue Shield PPO 80-K $30, Rx 5-20 PLAN ID: PPOBSL
GROUP NUMBER	**1H031001**	**1H081001**	**605337**	**0P031001**	**0P051001**
	Member Pays	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	**$0/$0**	**$0/$0**	**$0/$0**	**$300/$600**	**$1,000/$2,000**
Individual/Family Calendar Out-of-Pocket Max (includes medical co-pays, deductibles and co-insurance)	**$2,000/$4,000**	**$2,000/$4,000**	**$1,500/$3,000**	**$1,000/$3,000**	**$3,000/$6,000**
PROFESSIONAL SERVICES					
Office Visit/ Urgent Care co-pay	**$25**	**$25**	**$0**	**$20**	**$30**
Specialists/Consultants co-pay	**$25**	**$25**	**$0**	**$20**	**$30**
Prenatal, postnatal office visit co-pay	**$0**	**$0**	**$0**	**$20**	**$30**
Scans: CT, CAT, MRI, PET etc.	$0	$0	$0	10%	20%
Diagnostic X-ray & Laboratory Procedures	$0	$0	$0	10%	20%
Infertility (diagnosis/treatment of causes of infertility)	50%	50%	Not covered	Not covered	Not covered
Preventive Care Services (includes physical exams & screenings)	$0	$0	$0	0%, Deductible Waived	0%, Ded Waived
HOSPITAL & SKILLED NURSING FACILITY SERVICES					
Emergency Room visit co-pay (waived if admitted)	$100	$100	$100	$100 co-pay +10%	$100 co-pay +20%
Inpatient Hospital co-pay (preauthorization required)	$500	$500	$0	10%	20%
Outpatient Hospital co-pay	$500	$500	$0	10%	20%
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	$150	$150	N/A	10%	20%
Surgery, Outpatient (performed in a Hospital)	$300	$300	$0	10%	20%
MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT					
INPATIENT CARE: Facility based care (preauthorization required)	$500	$500	$0	10%	20%
OUTPATIENT CARE: Facility based care (preauthorization required)	$25	$25	$0	Deductible waived; OV co-pay applies	Deductible waived; OV co-pay applies
OTHER SERVICES					
Acupuncture - Limits apply	$10/30 visits combined w/chiro Use ASH network	$10/30 visits combined w/chiro Use ASH network	$10/30 visits combined w/chiro Use ASH network	10%	20%
Ambulance (Ground or Air)	$100	$100	$50	$100 co-pay + 10%	$100 co-pay + 20%
Chiropractic - Limits apply	$10/30 visits combined w/acu Use ASH Network	$10/30 visits combined w/acu Use ASH Network	$10/30 visits combined w/acu Use ASH Network	10%	20%
Durable Medical Equipment (DME)	20%	20%	$0	10%	20%
Hearing Aids	50% benfit allowance 1 device per 24 months Cost in excess allowance	50% benfit allowance 1 device per 24 months Cost in excess allowance		$700 benefit allowance per 24 month period Cost in excess allowance	$700 benefit allowance per 24 month period Cost in excess allowance
Physical and Occupational Therapy - Limits apply	$25	$25	$0	10%	20%
PRESCRIPTION DRUG PLANS					
Provider Network	**Navitus**	**Navitus**	**Kaiser**	**Navitus**	**Navitus**
Generic co-pay/days supply	$5 / 30-day	$5 / 30-day	$5 / 30-day	$7 / 30-day	$5 / 30-day
Brand co-pay/days supply	$20 / 30-day	$20 / 30-day	$5 / 30-day	$25 / 30-day	$20 / 30-day
Prescription Deductible Brand Drugs Only (ind/family)	No Rx Deductible	No Rx Deductible	No Rx Deductible	No Rx Deductible	No Rx Deductible
Mail Order (Generic-Brand co-pay/days supply)	$0 - $90 / 90-day	$0 - $90 / 90-day	$0 - $5 / 100-day	$0 - $60 / 90-day	$0 - $90 / 90-day
Prescription Drug Out-of-Pocket Maximum	$1,500 / $2,500	$1,500 / $2,500	$2,500 / $3,500	$1,500 / $2,500	$1,500 / $2,500

Note: This is a brief benefit summary that reflects in-network benefits from a participating or contracted provider. For additional details, limitations, exclusions and out-of-network coverage, please refer to the Summary of Benefits or Coverage Booklet. Plans with a deductible all have 4th quarter deductible carryover (October 1-December 31) except for the HDHP-HSA plan. Co-pays and co-insurance do not carryover to the next calendar year. To find a participating or contracting provider call the customer service number on your ID card or visit www.blueshieldca.com Pharmacy benefits have separate OOP Maximums when covered through Navitus.